

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

42865

State File No. \_\_\_\_\_

JAN 13 1942

Registration District No. 761Primary Registration District No. 6014Registrar's No. 40

## 1. PLACE OF DEATH

- (a) County St. Clair  
(b) City or town Rural Morgan Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: /

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution Home  
(Specify whether

In this community 47 yrs  
years, months or days)3. (a) PRINT  
FULL NAMEWilliam Clarence Shaver

## 3. (b) If veteran,

name war none

## 3. (c) Social Security

No. none

4. Sex Male 5. Color or race White  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if

alive \_\_\_\_\_ years  
(Day) (Year)

## 7. Birth date of deceased

Sept 15 - 1812  
(Month) (Day) (Year)

## 8. AGE:

Years

Months

Days

If less than one day

69278

hr. min.

## 9. Birthplace

Warsaw  
(City, town, or county)Ind  
(State or foreign country)

## 10. Usual occupation

Farming

## 11. Industry or business

12. Name Jordan L. Shaver

## 13. Birthplace

1 Tenn  
(City, town, or county)Smith  
(State or foreign country)

## 14. Maiden name

Erie1 Penn  
(City, town, or county)

## 15. Birthplace

Warsaw  
(City, town, or county)Ind  
(State or foreign country)

## 16. (a) Informant

Mrs Wallace H. Lawton

## (b) Address

Oscola Mo17. (a) Burial

(Burial, cremation, or removal)

## (b) Date thereof

See 16. 1941  
(Month) (Day) (Year)

## (c) Place: burial or cremation

Oscola Mo

## 18. (a) Signature of funeral director

Frank Lee

## (b) Address

Appleton City Mo19. (a) Dec. 14 - 41

(Date received local registrar)

(b) Mrs. Otto Roney

(Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State MO (b) County St. Clair

- (c) City or town Rural - Morgan Twp.  
(If outside city or town limits, write "RURAL")

- (d) Street No. \_\_\_\_\_ (If rural, give location)

- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)

If yes, name country 0

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 13

year 1941 hour 10 minute 30 A.M.

21. I hereby certify that I attended the deceased from 12 - 8

19 41, to 12 - 13, 19 41;that I last saw him alive on 12 - 11, 19 41;

and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_ Duration

Chronic MyocarditisMeningitisDue to Cerebral sinus thrombosisOrbital CellulitisDue to Apical abscess of tooth

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_

Of operations 8/12

Of autopsy \_\_\_\_\_

## 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_

- (b) Date of occurrence \_\_\_\_\_

- (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury 023. Signature R. L. Hammon (M. D. or other MO)Address Appleton City Mo Date signed 12-17-41

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 7,

District File Number 12-41-2141

Date Filed 1-8-42

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me

on the 13<sup>th</sup> day of Dec, Registered Apprentice No. \_\_\_\_\_  
working under my personal supervision.

Signed

Frank Lee

Licensed Embalmer No. 1099

P. O. Address

Appleton City, Wis.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.